DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 96 — 017

2. STATE: MA

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID) Title XIX

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
October 1, 1996

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447.250-299

7. FEDERAL BUDGET IMPACT:
a. FFY 97 $ 0
b. FFY 98 $ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19A(3)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Same

10. SUBJECT OF AMENDMENT:
State-Owned Non-acute Hospital Payment Methods

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Not Required Under 45 CFR 204.1

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Bruce M. Bullen

13. TYPED NAME:
Bruce M. Bullen

14. TITLE:
Commissioner

15. DATE SUBMITTED:
December 27, 1996

16. RETURN TO:
Bridget Landers
State Plan Coordinator
Division of Medical Assistance
600 Washington Street
Boston, MA 02111

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
December 30, 1996

18. DATE APPROVED:
JUN 06 2001

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
October 1, 1996

20. SIGNATURE OF REGIONAL OFFICIAL:
Dennis M. Mahoney for

21. TYPED NAME:
Ronald P. Preston

22. TITLE:
Associate Regional Administrator, DMSO

23. REMARKS:

OFFICIAL
JUN 06 2001

FORM HCFA-179 (07-92)

Instructions on Back

INSTITUTIONAL STATE PLAN
ASSURANCE AND FINDING CERTIFICATION STATEMENT

STATE: MA
TN: [redacted]

REIMBURSEMENT TYPE: **Inpatient hospital** X
Nursing facility
ICF/MR

PROPOSED EFFECTIVE DATES: 10/1/96

A. State Assurances and Findings. The State assures that it has made the following findings:

1. 447.253(b)(1)(i) - The State pays for inpatient hospital services and long-term care facility services through the use of rates that are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers to provide services in conformity with applicable State and Federal laws, regulations, and quality and safety standards. X

2. With respect to inpatient hospital services --

   a. 447.253(b)(1)(ii)(A) - The methods and standards used to determine payment rates take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs. X

   b. 447.253(b)(1)(ii)(B) - If a State elects in its State plan to cover inappropriate level of care services (that is, services furnished to hospital inpatients who require a lower covered level of care such as skilled nursing services or intermediate care services) under conditions similar to those described in section 1861(v)(1)(G) of the Act, the methods and standards used to determine payment rates must specify that the payments for this type of care must be made at rates lower than those for inpatient hospital level of care services, reflecting the level of care actually received, in a manner consistent with section 1861(v)(1)(G) of the Act. X

   If the answer is "not applicable," please indicate:

   c. 447.253(b)(1)(ii)(C) - The payment rates are adequate to assure that recipients have reasonable access, taking into account geographic location and reasonable travel time, to inpatient hospital services of adequate quality. X

3. With respect to nursing facility services --

   a. 447.253(b)(1)(iii)(A) - Except for preadmission screening for individuals with mental illness and mental retardation under 42 CFR 483.20(f), the methods and standards used to determine payment rates take into account the costs of complying with the requirements of 42 CFR part 483 subpart B. N/A

b. 447.253(b)(1)(iii)(B) - The methods and standards used to determine payment rates provide for an appropriate reduction to take into account the lower costs (if any) of the facility for nursing care under a waiver of the requirement in 42 CFR 483.30(c) to provide licensed nurses on a 24-hour basis.

N/A

c. 447.253(b)(1)(iii)(C) - The State has established procedures under which the data and methodology used to establish payment rates are made available to the public. N/A

4. 447.253(b)(2) - The proposed payment rate will not exceed the upper payment limits as specified in 42 CFR 447.272:

a. 447.272(a) - Aggregate payments to each group of health care facilities (hospitals, nursing facilities, and ICFs/MR) will not exceed the amount that can reasonably be estimated would have been paid for those services under Medicare payment principles.

X

b. 447.272(b) - Aggregate payments to each group of State-operated facilities (that is, hospitals, nursing facilities, and ICFs/MR) -- when considered separately -- will not exceed the amount that can reasonably be estimated would have been paid for under Medicare payment principles. X
If there are no State-operated facilities, please indicate "not applicable:" _____

c. 447.272(c) - Aggregate disproportionate share hospital (DSH) payments do not exceed the DSH payment limits at 42 CFR 447.296 through 447.299.

X

d. Section 1923(g) - DSH payments to individual providers will not exceed the hospital-specific DSH limits in section 1923(g) of the Act.

X

B. State Assurances. The State makes the following additional assurances:

1. For hospitals --

a. 447.253(c) - In determining payment when there has been a sale or transfer of the assets of a hospital, the State's methods and standards provide that payment rates can reasonably be expected not to increase in the aggregate solely as a result of changes of ownership, more than payments would increase under Medicare under 42 CFR 413.130, 413.134, 413.153 and 413.157 insofar as these sections affect payment for depreciation, interest on capital indebtedness, return on equity (if applicable) acquisition costs for which payments were previously made to prior owners, and the recapture of depreciation.

X

2. For nursing facilities and ICFs/MR--

   a. 447.253(d)(1) - When there has been a sale or transfer of the assets of a NF or ICF/MR on or after July 18, 1984 but before October 1, 1985, the State's methods and standards provide that payment rates can reasonably be expected not to increase in the aggregate, solely as a result of a change in ownership, more than payments would increase under Medicare under 42 CFR 413.130, 413.134, 413.153 and 413.157 insofar as these sections affect payment for depreciation, interest on capital indebtedness, return on equity (if applicable), acquisition costs for which payments were previously made to prior owners, and the recapture of depreciation. N/A

   b. 447.253(d)(2) - When there has been a sale or transfer of the assets of a NF or ICF/MR on or after October 1, 1985, the State's methods and standards provide that the valuation of capital assets for purposes of determining payment rates will not increase (as measured from the date of acquisition by the seller to the date of the change of ownership) solely as a result of a change of ownership, by more than the lesser of:

   (i) 1/2 of the percentage increase (as measured from the date of acquisition by the seller to the date of the change of ownership) in the Dodge construction index applied in the aggregate with respect to those facilities that have undergone a change of ownership during the fiscal year; or

   (ii) 1/2 of the percentage increase (as measured from the date of acquisition by the seller to the date of the change of ownership) in the Consumer Price Index for All Urban Consumers (CPI-U) (United States city average) applied in the aggregate with respect to those facilities that have undergone a change of ownership during the fiscal year. N/A

3. 447.253(e) - The State provides for an appeals or exception procedure that allows individual providers an opportunity to submit additional evidence and receive prompt administrative review, with respect to such issues as the State determines appropriate, of payment rates.
   X

4. 447.253(f) - The State requires the filing of uniform cost reports by each participating provider.
   X

5. 447.253(g) - The State provides for periodic audits of the financial and statistical records of participating providers.
   X

6. 447.253(h) - The State has complied with the public notice requirements of 42 CFR 447.205.

Notice published on: September 23, 1996

If no date is shown, please explain: _____

7. 447.253(i) - The State pays for inpatient hospital and long-term care services using rates determined in accordance with the methods and standards specified in the approved State plan.

X

C. Related Information

1. 447.255(a) - NOTE: If this plan amendment affects more than one type of provider (e.g., hospital, NF, and ICF/MR; or DSH payments) provide the following rate information for each provider type, or the DSH payments. You may attach supplemental pages as necessary.

Provider Type: **STATE-OWNED NONACUTE HOSPITAL**

For hospitals: Include DSH payments in the estimated average rates. You may either combine hospital and DSH payments or show DSH separately. If including DSH payments in a combined rate, please initial that DSH payment are included.
Estimated average proposed payment rate as a result of this amendment: $486.69
Average payment rate in effect for the immediately preceding rate period: $398.21
Amount of change: $ 88.48 Percentage of change: +22.22%

2. 447.255(b) - Provide an estimate of the short-term and, to the extent feasible, long-term effect the change in the estimated average rate will have on:

(a) The availability of services on a statewide and geographic area basis: NO EFFECT

(b) The type of care furnished: NO EFFECT

(c) The extent of provider participation: NO EFFECT

(d) For hospitals -- the degree to which costs are covered in hospitals that serve a disproportionate number of low income patients with special needs: **The change more accurately covers the patient care costs of state-owned non-acute hospitals that serve a disproportionate number of law income patients with special needs**

I HEREBY CERTIFY that to the best of my knowledge and belief, the information provided is true, correct, and a complete statement prepared in accordance with applicable instructions.

Completed by Dan Dowell Date 12/27/96
Title: _____

State Plan Under Title XIX of the Social Security Act
Massachusetts Medical Assistance Program

Methods Used to Determine Rates of Payment for Services in State-Owned Nonacute Hospitals

I. General Description of Prior and Current Reimbursement Methodology

State-owned nonacute hospitals participating in the Massachusetts Medical Assistance Program include chronic disease and rehabilitation hospitals and psychiatric hospitals.

The basic reimbursement methodology described in this attachment was effective October 1, 1985 for most state-owned nonacute hospitals with rate years beginning October 1, and was phased in during the course of the rate year for the remaining state-owned nonacute hospitals. **Changes are now proposed in response to passage of M.G.L. c. 118E, ss 13A and M.G.L. c. 118G.** All state-owned nonacute hospitals are governed by 114.1 CMR 40.00. the regulation that implements this methodology. These provisions do not apply, however, to ICF/MRs having more than 15 beds, which are reimbursed under 114.1 CMR 29.00.

I.A. The following is a general description of the chief components of the reimbursement method for state-owned nonacute hospital services existing since 1985.

1. Hospital allowable costs, with the exception of the working capital component, are determined from a base year that has been fixed at FY93. Expenses disallowed in the base year are never rolled into payment rates for subsequent years. The establishment of a fixed-base year, therefore, provides a strong incentive for cost efficiency. Rates of payment are adjusted to affect appropriate cost increases or decreases resulting from changes in volume, case-mix, inflation, and other factors. The working capital component is determined from the operating and capital requirements of the rate year.

2. Rates of payment have a direct relationship to the actual charges incurred by a patient based on the services utilized by that patient. Under this charge-based system hospitals are able to charge more for patients who require more or heavier care. Thus, this system is responsive to hospital financial needs in the face of changing casemix.

3. A payment-on-account factor (PAF), is the initial rate of payment equal to the product of the PAF and the charge for the services. The PAF is computed for each hospital by dividing the RFR by the approved GPSR for the corresponding rate year. In no event shall the PAF exceed 100% of a hospital's charge for services.

I.B. The following describes the changes made to implement various provisions of Chapter 270 of the Acts of 1988.

1. The Commonwealth will now establish a separate per-diem rate of **$113.27** for routine services furnished to administrative day patients. Ancillary services furnished to administrative day patients will be reimbursed through a PAF applied to charges, precisely like the method for hospital level inpatient and outpatient services. (Payments for administrative days were previously reimbursed through a single PAF applied to charges for all inpatient hospital services. This PAF was adjusted by using an Administrative Day Penalty Factor which reduced the rate sufficiently to reflect payments for appropriate levels of care.)

2. The Commonwealth will adjust rates of payment to compensate state-owned nonacute hospitals for cost increases related to recruiting and retaining direct-care labor. Rates will be adjusted in two ways: 1) the inflation adjustment used to derive the rate year operating costs will be increased to reflect the increased costs of direct care personnel in the Commonwealth; and 2) hospitals which can demonstrate extraordinary cost increases for direct care personnel, in excess of the amount allowed through inflation, will receive an

adjustment as a cost beyond control.

3. A state-owned nonacute hospital will receive a supplementary payment for its hospital level of payments to ensure that payments for services to publicly assisted patients meet total reasonable hospital costs.

The method of payment for state-owned nonacute hospital services, including the changes indicated above, are explained in greater detail below.

II. Definitions

Adjusted Base Year Volume. The actual base year volume adjusted to include the volume associated with recurring CBCs, new services and transfers on of cost and exclude volume associated with discontinued services and transfers off of cost.

Administrative Day (AD). An inpatient day spent in a state-owned nonacute hospital or public health care facility, other than a hospital operated by the Department of Mental Health (except facilities that are certified to provide services under Title XIX of the Social Security Act), by a patient who no longer requires hospital level of care.

Base Year. Base year shall mean the hospital's fiscal year 1993.

Charge. The amount to be billed or charged by a hospital for each specific service within a revenue center.

CBC. Cost Beyond Control.

Department of Public Health. The Department of Public Health established under M.G.L. c. 17,§.1.

DHCFP. The Division of Health Care Finance and Policy established under M.G.L. c. 118G, formerly the Rate Setting Commission.

DHCFP-450. A report which documents a hospital's charges and volume, utilized for the purpose of adjusting the cost-to-charge ratio or the payment

on account factor should the facility increase their charges.

Discontinued Service. A health service, supply or accommodation which:
(a)is included in the adjusted base year cost and which will not be offered during the rate year, or
(b)is being offered and terminated during the rate year.

Direct Cost. The cost of a health service, supply or accommodation, excluding administrative, overhead and capital costs.

Division. the Massachusetts Division of Medical Assistance organized under M.G.L. c. 18.

Gross Patient Service Revenue (GPSR). The total dollar amount of a hospital's charges for services rendered **during the reporting period, generally within** a fiscal year.

Intermediate Year. The hospital fiscal year just before the current rate year.

Non-Charge Payers Reimbursement. The amount received or estimated to be received by the hospital from all payers reimbursing a hospital on a less-than-full-charge basis, including but not limited to, the Commonwealth of Massachusetts for the publicly aided inpatient rate and workmen's compensation inpatient rate, the Secretary of the U.S. Department of Health and Human Services for Medicare inpatient and outpatient hospital services under 42 U.S.C. 1395 et seq., and Massachusetts Blue Cross, Inc., for inpatient and outpatient services. A contracting agency under 114.1 CMR 40.00 shall not be considered a cost-based payer.

PAF. Payment on account factor is a percentage applied to charges to calculate a purchaser's discounted reimbursement level.

Public Health Care Facility. A facility operated by the Department of Public Health, the Department of Mental Health, a County of the Commonwealth, or a Soldiers' Home which provides inpatient medical, skilled nursing, or mental retardation care and services and which may provide outpatient medical, mental health, or mental retardation care services.

Publicly Aided Individual. A person who received health care and services

for which a governmental unit is in whole or part liable under a statutory program of public assistance.

Rate Year. The hospital fiscal year during which the change in Medicaid rate is to take effect.

Reasonable Financial Requirements (RFR). The sum of a hospital's rate year operating requirements, rate year capital requirements, and rate year working capital requirements.

State-Owned Nonacute Hospital. A hospital that is operated by the Massachusetts Department of Public Health (DPH) with less than a majority of medical-surgical, pediatric, maternity, and obstetric beds, or any psychiatric facility operated by the Department of Mental Health (DMH).

Transfer of Cost. An increase (transfer on) or decrease (transfer off) of hospital costs related to persons or entities that provide hospital care or services, and which change compensation arrangements from non-hospital based to hospital based (transfer on) or from hospital based to non-hospital based (transfer off). A transfer on of physician compensation will only be allowed if reasonable.

III. Medicaid Reimbursement Methodology for State-Owned Nonacute Hospitals

For any particular rate year, a provider-specific Medicaid payment-on-account factor (PAF) will be calculated. This PAF is, in turn, applied to charges billed to the Division by the hospital. The PAF is the result of dividing the ratio of the hospital's rate year allowable costs, called "RFR" by the rate year total charges, called "GPSR". **For fiscal year 1997, the PAF shall be computed by dividing the fiscal year 1997 RFR by the fiscal year 1997 GPSR. This PAF will remain in effect unless it is adjusted as required.**

The process required to determine the Medicaid payment-on-account factor involves the following steps:

- o the determination of allowed base-year costs;
- o the adjustment of allowed base-year costs to the rate year;

- o the determination of reasonable financial requirements (RFR) for the rate year; and
- o the determination of approved gross patient revenue service for the rate year.

Each of these steps is explained in greater detail below.

III.A. Determination of Allowed Base-Year Costs

Each hospital must file with DHCFP reports of its costs, revenues, statistics, charges, and other related information in accordance with time frames and reporting mechanisms specified in 114.1 CMR 40.03.

1. Allowed Capital Costs

The base-year allowed capital cost is calculated as the sum of the base year cost of depreciation expense for building and fixed equipment, reasonable interest expense, amortization and leases and rental of facilities, subject to the limitations contained in 114.1 CMR 40.07(3) (See Appendix I.).

2. Allowed Operating Costs

a. The base-year allowed operating costs are established using actual 1993 fiscal year operating costs. This includes only costs incurred or to be incurred in the provision of hospital care and services, supplies, and accommodations and determined in accordance with the Principles of Reimbursement for Provider Costs under 42 U.S.C. ss. 1395 et seq. as set forth in 42 CFR 413 et seq. and the Provider Reimbursement Manual as well as Generally Accepted Accounting Principles and the reporting requirements set forth in 114.1 CMR 40.03 (See Appendix I.).

b. The base-year allowed operating costs do not include costs of personnel or consultants where the primary purpose is, either directly or indirectly, to persuade or seek to persuade hospital employees to support or oppose unionization.

c. The base-year allowed operating costs shall be adjusted whenever an audit discloses that base year operating costs expended by a hospital were not reasonable and necessary for the care of publicly-aided patients and did not meet the standards set forth in Section III.A.2.a of this State Plan Amendment. The base-year allowed operating costs shall also be adjusted for discontinued costs and transfer of costs since the base year.

III.B. Adjustment of Allowed Base-Year Costs to the Rate Year

Allowed base-year operating and capital costs are adjusted for additional costs projected to occur in the rate year. These additional costs fall into the major categories of inflation, volume, costs beyond control (CBC), new services and capital.

1. Inflation

For fiscal year 1997, DHCFP will adjust allowed base-year operating costs using a composite index comprised of two cost categories: labor and non-labor. These categories shall be weighted according to the weights used by the Health Care Financing Administration for PPS-exempt hospitals. The inflation proxy for the labor cost category shall be the Massachusetts Consumer Price Index. The inflation proxy for the non-labor category shall be the non-labor portion of the HCFA market basket for hospitals. The composite inflation index will be increased by .02 pursuant to M.G.L.c. 118G. The composite inflation index for fiscal year 1997 shall be 2.05% for all hospitals.

2. Volume

Allowed base-year operating costs shall be further adjusted to

reflect reasonable volume increases and decreases as follows:

(a) The Division shall require each hospital to report its costs, revenue, and volume data in accordance with the reporting requirements contained in 114.1 CMR 40.03. For purposes of calculating the volume adjustment, the Allowed Unit Cost for each cost center shall equal the base year direct and indirect costs for that cost center divided by the year units. The volume associated with a Determination of Need (DoN) project, new service, or transfer on of cost shall be part of the volume used in the computation of the volume allowance. Any allowance due to new services, DoN, or transfer-on volume shall be netted out if the costs associated with it are submitted as new services, CBCs or transfers.

(b) For projected volume increases or decreases from the intermediate year to the rate year which are greater or equal to 10%, the hospital must submit a supporting statement of explanation accompanied by the appropriate statistical documentation. No volume increase shall be allowed without such explanation and documentation.

(c) For routine inpatient care services and routine ambulatory services, the allowed marginal cost for a unit increase or decrease in volume shall be 50%. The allowed cost for marginal cost for ancillary services for a unit increase or decrease in volume shall be 60%. There shall be no upside corridors for volume increases.

(d) An increase in costs due to an increase in routine inpatient services or routine ambulatory services volume from the base year to the rate year shall be calculated as the product of the projected increase in units multiplied by 50% of the allowed unit cost inflated by the base to rate year composite inflation index.

An increase in costs due to an increase in ancillary

services volume from the base year to the rate year shall be calculated as the product of the projected increase in units multiplied by 60% of the allowed unit cost inflated by the base to rate year composite inflation index.

(e) For routine inpatient care services, routine ambulatory services and ancillary services, the allowed marginal cost for a unit decrease in volume shall be as follows:

Unit Decrease	Allowed Marginal Cost
Up to 5%	100%
Over 5% to 25%	50%
Over 25% to 50%	25%
Over 50% to 75%	12.5%
Over 75%	0%

There shall be no downside corridors for volume decreases.

(f) A decrease in cost due to a decrease in routine inpatient care service, routine ambulatory care services or ancillary services volume shall be calculated as the product of the projected decrease in units multiplied by one minus the applicable marginal cost percentage, as describes above, multiplied by the Allowed Unit Cost inflated by the base to rate year composite inflation index.

3. Costs Beyond Hospital Control (CBCs)

A. Under specific circumstances, a state-owned non-acute Hospital may request an increase in its allowed base year operating costs to include cost increases due to CBCs. A CBC is an unusual and unforeseen increase in reasonable and allowable costs which is solely attributable to unique and exceptional circumstances that are beyond the control of the hospital. The following requirements must be met before certain costs are qualified as CBCs and included in the hospital's operating requirement.

(1) A cost shall not be determined to be a CBC if in a prior fiscal year the DHCFP approved costs corresponding to the CBC and the events giving rise to the cost did not take place in the year the cost was approved.

(2) The hospital shall demonstrate that the category of cost of the requested CBC is not included in the adjusted base year operating cost or in the inflation and volume allowances.

(3) The timing and amount of the increase in costs must be reasonably certain. If the hospital does not begin to expend costs for which it has received a CBC adjustment within six months, the hospital must notify DHCFP that approved amounts were not expended and the DHCFP will deduct such costs from RFR.

(4) A CBC shall be allowable only if the amount requested is greater than one- tenth of 1% of the hospital's total patient care costs.

(5) Multiple unrelated CBC requests for any one cost beyond control category must not be grouped together. Each individual CBC request for a particular item must meet the materiality limit specified in (4) above.

(6) A CBC shall be allowable only if necessary for the appropriate provision of services to publicly aided individuals and if the costs cannot otherwise be met through efficient management and economic operation.

B. The following are the qualifying incidents or circumstances for CBCs:

(1) Costs generated by correcting deficiency contingencies or recommendations for failure to comply with changes in government requirements related to hospital licensure and participation in programs of hospital care and services under 42 U.S.C.§§1395 et seq. and 42 U.S.C.§§ 1396 et seq. An example of this category is a cost incurred or expected to be incurred within six (6) months to comply with a change in the manual issued after 1984 by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). Costs of complying with standards contained in the manual before 1985 or costs which merely recommend improvement will not be considered as a CBC. Hospitals which have not previously been accredited by JCAHO will be allowed reasonable costs of complying with accreditation standards of the JCAHO contained in its manual. An example of cost which would not be considered to be A CBC is expanded emergency room coverage. Also, increased utilization review costs which are not due to any allowable CBC shall not be recognized. Documentation shall include a copy of the government requirement or contingency/recommendation, verification of the increased costs and verification that the increased costs are reasonable to meet the government requirement.

(2) Costs generated by compliance with changes in government requirements which are set forth in federal or state regulations which mandate non-discretionary hospital expenditures. However, if the costs fall within a category encompassed by an inflation factor, it shall not be allowed as a cost beyond reasonable hospital control. Documentation shall include a copy of the government requirement or contingency/recommendation, verification of the

costs, and verification that the increase in costs requested is reasonable to meet the government requirement.

(3) Costs generated by disaster losses in excess of insurance or extraordinary costs related to disaster losses not covered by outside sources. Documentation shall include verification of loss or extraordinary cost and the insurance or outside source payment. If, however, the loss or extraordinary cost is caused by a facility being inadequately insured according to the standards of the hospital industry, or through negligence on the part of hospital management, such losses or costs shall not be approved.

(4) Allowed operating costs associated with a major capital expenditure or substantial change in services which is subject to and has received a determination of need pursuant to M.G.L. c. 111, §§25B - 25G. These costs must be segregated from other allowed operating costs. The hospital must demonstrate that the increased cost requests are reasonable. The hospital will not be permitted to make a volume adjustment for departments affected by a determination of need if the hospital requests that the operating cost associated with the determination of need be included as a CBC. Any volume allowance due to DoN shall be netted out if costs associated with it are submitted as a CBC.

(5) Wage parity adjustments resulting from mergers which are clearly demonstrated to be cost-effective. The term "cost-effective" used in this context shall mean that at the end of three years the merged hospitals are spending less than the individual hospitals have projected, and in no event are spending more than the combined

projections of both hospitals. Documentation shall include a copy of the merger agreement and projections of costs without the merger as well as projection of the cost savings to be achieved through the merger. This adjustment will be considered a non-recurring cost beyond control and the costs associated with it will be subtracted from rate year costs for any year in which the rate year becomes the base year for future rates.

(6) Intra-hospital wage and salary adjustments which are clearly demonstrated to be cost-effective. The term "cost-effective" as used in this context shall mean that at the end of three years the hospital is spending less than it would have without the wage and salary adjustments.

(a) Documentation shall provide a projection of the costs savings to be achieved as a result of adjustments to wages and salaries.

(b) This adjustment will be considered a non-recurring cost beyond control. Costs associated with this CBC will be subtracted from rate year costs for any year in which the rate year becomes the base year for future rate years.

(7) Costs for reasonable increases in direct care staff salaries and wages in excess of the amount allowed through inflation. This CBC is not to exceed actual expenditures for such increases.

(a) Wage relief may be requested for technicians, nurses, nursing aides, orderlies, attendants, occupational therapists, speech therapists, recreational therapists, physical therapists, and respiratory therapists. Any personnel in these

categories who are primarily conducting administrative job duties and are not directly involved with providing patient care are not eligible for CBC allowance.

(b) The CBC for reasonable increases in direct care staff salaries and wages is defined as the reasonable rate year wage rate less the inflated base year wage rate, times the lesser of the rate year FTE direct care labor force or the base year FTE direct care labor force.

(c) The inflation allowance for direct care staff includes the full amounts granted in Section III.B.1.

(d) The reasonable rate year wage shall be the level of increase required to attract sufficient staff to ensure minimum availability of care as determined by the Department of Public Health for current patients. The wage rate will be determined by the Division with reference to average rates prevailing at other hospitals within the same Medicare labor market region, subject to the following conditions:

(i) Outlier wage rates as defined by the Division shall be excluded from the computation;

(ii) Special weight shall be given to rates prevailing at non-acute hospitals located in the hospital's Medicare labor market region;

(iii) If it can be demonstrated that direct care staff at a hospital are